PA03-2002: ERECTILE DYSFUNCTION REQUEST

RI MEDICAL ASSISTANCE PROGRAM
PRIOR AUTHORIZATION REQUEST FORM

NOT REQUIRED FOR RECIPIENTS UNDER 21 YEARS OF AGE.

FAX OR MAIL TO:
HERITAGE INFORMATION SYSTEMS
ATTN: RI PRIOR AUTHORIZATION UNIT
PO BOX 25719
RICHMOND VA 23286-8212
FAX # 1-800-390-0109

CLIENT NAME _____ DOB: _____ SEX: M F (CIRCLE ONE – ED APPROVED FOR MALES ONLY)

MEDICAID ID NUMBER: _____

PRESCRIBER NAME: _____ PRESCRIBER DEA #: _____

PRESCRIBER OFFICE ADDRESS: _____

_____

OFFICE PHONE NUMBER ( ) _____- _____

REQUESTER NAME: _____ RN /MD /R.PH / _____

PHONE NUMBER ( )_____-_____ FAX NUMBER ( )_____-_____

DRUG REQUESTED : _____ QTY / FILL _____

REQUEST TYPE: (CIRCLE ONE) INITIAL / REAUTHORIZATION START DATE: _____ DOSING FREQUENCY: ____

DURATION OF THERAPY: 1 3 6 9 12 MONTHS (CIRCLE ONE) UNITS / RX _____ (APPROVAL GRANTED FOR 8 OR LESS DOSES PER MONTH)

INDICATE THE RELEVANT DIAGNOSIS WITH APPROPRIATE ICD-9 CODE.

CRITERIA SPECIFICATIONS ARE AVAILABLE BY CALLING **(401) 784-8100** OR AT WEB ADDRESS www.dhs.ri.gov/dhs/heacre/provsvcs/mpharpa.htm

ERECTILE DYSFUNCTION	ICD9 CODE

OTHER	ICD9 CODE

HAS THE PATIENT TRIED OTHER TREATMENT OPTIONS? IF YES, PLEASE DOCUMENT:

LIST POSSIBLE CAUSES THAT HAVE BEEN DOCUMENTED:

COMMENTS:

PRESCRIBER SIGNATURE _____ **DATE** _____

By Signature, the Prescriber confirms the criteria information above is accurate, verifiable by client records and available for review upon request.

PA # _____ **APPROVED**_____

DENIED _____

PENDING ADDITIONAL INFORMATION_____

DATE /TIME OF RECEIPT _____

DATE/TIME RESPONSE _____

REVIEWER _____

COMMENTS:

RI PRIOR AUTHORIZATION CALL CENTER
FAX NUMBER 1-800-390-0109 *(AVAILABLE 24 HOURS)*
TELEPHONE NUMBER 1-866-420-3874

RI PRIOR AUTHORIZATION - CALL CENTER HOURS
MONDAY – FRIDAY 9:00 AM – 6:00 PM (EST)
SATURDAYS 9:00 AM – 1:00 PM (EST)